HOUSE BILL No. 1323

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-11-10; IC 27-13-15-5.

Synopsis: Dialysis treatment coverage. Specifies requirements for an accident and sickness insurer and a health maintenance organization with respect to providing coverage for dialysis treatment, including payment rates, changes in coverage, networks of dialysis treatment providers, and filings.

Effective: July 1, 2008.

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January 15, 2008, read first time and referred to Committee on Insurance.

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Introduced

Second Regular Session 115th General Assembly (2008)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

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HOUSE BILL No. 1323

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: **Sec. 10. (a) Notwithstanding section 1 of this chapter, as used in this section, "insured" refers only to an insured who requires dialysis treatment.**

(b) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

(c) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(d) An insurer may not establish a payment rate to be paid for a health care service rendered by a dialysis treatment provider that has not entered into an agreement with the insurer under this chapter unless the insurer does the following:

(1) Consults and comes to an agreement with the dialysis treatment provider concerning the payment rate.

(2) Establishes the payment rate considered to be reasonable

and customary for the health care service, based on factors that include the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider for the health care service in the geographic area.

(D) The economics of the dialysis treatment provider's practice.

(3) Does not consider Medicare and Medicaid payment rates.

(4) Sets the payment rate at an amount that is equal to or greater than the payment rate that applies to a dialysis treatment provider that has entered into an agreement with the insurer under this chapter.

(e) An insurer may not do any of the following at any time after the open enrollment period during which the insured becomes covered under a group policy of accident and sickness insurance:

(1) Restrict benefits or increase costs to an insured in relation to dialysis treatment, unless the insured becomes eligible for Medicare.

(2) Change coverage or benefits in any way that would affect dialysis treatment, unless the insurer, not later than one hundred eighty (180) days before the change becomes effective, provides written notice of the change to the insured and dialysis treatment provider, including a description of the:

(A) rationale for the change;

(B) proposed effect of the change on coverage of dialysis treatment; and

(C) methodology used to determine a proposed payment rate change.

(f) An insurer may not attempt to facilitate coverage of an insured under the Medicare program and may not change the insured's coverage under any policy of accident and sickness insurance from primary coverage to secondary or supplemental coverage.

(g) An insurer may not:

(1) require an insured, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the insured's home to obtain dialysis treatment; or

(2) if a dialysis treatment provider that has entered into an

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agreement with the insurer under this chapter is not available within the distance or time specified in subdivision (1), require the insured to pay a higher cost for dialysis treatment provided within the distance or time specified in subdivision (1) by a dialysis treatment provider that has not entered into an agreement with the insurer under this chapter.

(h) An insurer shall pay a dialysis treatment provider that:

(1) has not entered into an agreement with the insurer under this chapter; and

(2) provides dialysis treatment to an insured as described in subsection (g)(2);

the same amount that the insurer would pay to a dialysis treatment provider that has entered into an agreement with the insurer under this chapter.

(i) Regardless of whether a dialysis treatment provider has entered into an agreement under this chapter with an insurer, the following apply:

(1) An insurer shall pay only the dialysis treatment provider and not the insured.

(2) An insurer or a dialysis treatment provider shall not involve an insured in a payment dispute between the insurer and dialysis treatment provider.

(3) An insurer shall honor an insured's assignment of benefits under a policy of accident and sickness insurance to a dialysis treatment provider.

(4) An insurer shall not question the appropriateness of a physician's treatment of an insured.

(j) The following apply to an insurer's network of all dialysis treatment providers that have entered into an agreement with the insurer under this chapter:

(1) The insurer shall file with the department an annual evaluation of whether the network is sufficient to provide health care services to insureds covered under a policy of accident and sickness insurance issued by the insurer. The commissioner shall, not more than thirty (30) days after receiving a filing under this subdivision, approve the filing or make recommendations for changes to the network.

(2) Before any proposed change to the network, the insurer shall:

(A) file with the department an analysis of the manner in which the proposed change will affect insured access to dialysis treatment, quality of care, and premium rates; and

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(B) demonstrate to the commissioner that the proposed change will not result in a shift of coverage from commercial health coverage to government funded coverage for insureds who will be affected by the proposed change.

(3) The insurer may not implement a proposed change described in subdivision (2) until the commissioner approves the proposed change.

(4) The network must at all times include not less than seventy percent (70%) of the dialysis treatment providers in Indiana.

(5) If the network at any time does not meet the requirement of subdivision (1), any agreement entered into between a dialysis treatment provider and the insurer in Indiana is void.

(k) The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 2. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.**

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) A health maintenance organization may not establish a payment rate to be paid for a health care service rendered by a dialysis treatment provider that is not a participating provider unless the health maintenance organization does the following:

(1) Consults and comes to an agreement with the dialysis treatment provider concerning the payment rate.

(2) Establishes the payment rate considered to be reasonable and customary for the health care service, based on factors that include the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider for the health care service in the geographic area.

(D) The economics of the dialysis treatment provider's practice.

(3) Does not consider Medicare and Medicaid payment rates.

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(4) Sets the payment rate at an amount that is equal to or greater than the payment rate that applies to a dialysis treatment provider that is a participating provider.

(d) A health maintenance organization may not do any of the following at any time after the open enrollment period during which the enrollee becomes covered under a group contract:

(1) Restrict benefits or increase costs to an enrollee in relation to dialysis treatment, unless the enrollee becomes eligible for Medicare.

(2) Change coverage or benefits in any way that would affect dialysis treatment, unless the health maintenance organization, not later than one hundred eighty (180) days before the change becomes effective, provides written notice of the change to the enrollee and dialysis treatment provider, including a description of the:

(A) rationale for the change;

(B) proposed effect of the change on coverage of dialysis treatment; and

(C) methodology used to determine a proposed payment rate change.

(e) A health maintenance organization may not attempt to facilitate coverage of an enrollee under the Medicare program and may not change the enrollee's coverage under any individual contract or group contract from primary coverage to secondary or supplemental coverage.

(f) A health maintenance organization may not:

(1) require an enrollee, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the enrollee's home to obtain dialysis treatment; or

(2) if a dialysis treatment provider that is a participating provider is not available within the distance or time specified in subdivision (1), require the enrollee to pay a higher cost for dialysis treatment provided within the distance or time specified in subdivision (1) by a dialysis treatment provider that is not a participating provider.

(g) A health maintenance organization shall pay a dialysis treatment provider that:

(1) is not a participating provider; and

(2) provides dialysis treatment to an enrollee as described in subsection (f)(2);

the same amount that the enrollee would pay to a dialysis

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treatment provider that is a participating provider.

(h) Regardless of whether a dialysis treatment provider is a participating provider, the following apply:

(1) A health maintenance organization shall pay only the dialysis treatment provider and not the enrollee.

(2) A health maintenance organization or a dialysis treatment provider shall not involve an enrollee in a payment dispute between the health maintenance organization and dialysis treatment provider.

(3) A health maintenance organization shall honor an enrollee's assignment of benefits under an individual contract or group contract to a dialysis treatment provider.

(4) A health maintenance organization shall not question the appropriateness of a physician's treatment of an enrollee.

(i) The following apply to a health maintenance organization's network of all dialysis treatment providers that are participating providers:

(1) The health maintenance organization shall file with the department an annual evaluation of whether the network is sufficient to provide health care services to enrollees covered under an individual contract or a group contract entered into by the health maintenance organization. The commissioner shall, not more than thirty (30) days after receiving a filing under this subdivision, approve the filing or make recommendations for changes to the network.

(2) Before any proposed change to the network, the health maintenance organization shall:

(A) file with the department an analysis of the manner in which the proposed change will affect enrollee access to dialysis treatment, quality of care, and premium rates; and

(B) demonstrate to the commissioner that the proposed change will not result in a shift of coverage from commercial health coverage to government funded coverage for enrollees who will be affected by the proposed change.

(3) The health maintenance organization may not implement a proposed change described in subdivision (2) until the commissioner approves the proposed change.

(4) The network must at all times include not less than seventy percent (70%) of the dialysis treatment providers in Indiana.

(5) If the network at any time does not meet the requirement of subdivision (1), any agreement entered into between a

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dialysis treatment provider and the health maintenance organization in Indiana is void.

(j) The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 3. [EFFECTIVE JULY 1, 2008] **(a) The department of insurance shall, not later than December 31, 2008, conduct a comprehensive review of filings made with the department of insurance:**

(1) by an insurer described in IC 27-8-11, as amended by this act, to determine compliance with IC 27-8-11, as amended by this act; and

(2) by a health maintenance organization described in IC 27-13-15-5, as added by this act, to determine compliance with IC 27-13-15-5, as added by this act.

(b) If the department of insurance determines that an insurer or health maintenance organization is not in compliance, as described in subsection (a), the department of insurance shall notify the insurer or health maintenance organization of the noncompliance, and the insurer or health maintenance organization shall prove compliance not later than sixty (60) days after the insurer or health maintenance organization receives notice of noncompliance under this subsection.

(c) An insurer described in IC 27-8-11, as amended by this act, and a health maintenance organization described in IC 27-13-15-5, as added by this act, shall do the following:

(1) The insurer shall inform the department of insurance of any violation by the insurer of IC 27-8-11, as amended by this act, and correct the violation not later than sixty (60) days after providing notice to the department of insurance under this subdivision.

(2) The health maintenance organization shall inform the department of insurance of any violation by the health maintenance organization of IC 27-13-15-5, as added by this act, and correct the violation not later than sixty (60) days after providing notice to the department of insurance under this subdivision.

(d) Failure of an insurer or a health maintenance organization to comply with subsection (b) or (c) of this SECTION is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 4. [EFFECTIVE JULY 1, 2008] **(a) IC 27-8-11-10, as added by this act, applies to an agreement between an insurer and**

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a dialysis treatment provider that is entered into, amended, or renewed on or after June 30, 2008.

(b) IC 27-13-15-5, as added by this act, applies to a contract between a health maintenance organization and a dialysis treatment provider that is entered into, amended, or renewed after June 30, 2008.

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